

Medical Condition	How often	Dose	Medications	Medical Condition	How often	Dose	Medications

List all medications, prescriptions, Over the Counter, Herbal, Vitamins, etc.

Medical Conditions

- ☐ Asthma ☐ Cancer ☐ Diabetes
☐ Heart Disease ☐ Hypertension/High Blood Pressure
☐ Kidney Disease
☐ Other (Please list) _____

Date of Last Adult Immunizations

Flu _____ MMR _____
 Pneumonia _____ Tetanus/
 diphtheria _____

Other Information

1. Have you ever received anesthesia? ☐ Yes ☐ No
 2. Did you have an unexpected reaction? ☐ Yes ☐ No
 If yes, please explain _____

1. Have you ever received blood? ☐ Yes ☐ No
 2. Did you have an unexpected reaction? ☐ Yes ☐ No
 If yes, please explain _____

MEDICAL INFORMATION FOR:

Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

Doctor: _____ Phone: _____

Emergency contact: _____

Relationship: _____

Phone: _____

Allergies to Medications: _____

Information Current as of: _____

DeWitt Health Care Network

PERSONAL MEDICAL FILE



Use **pencil** for
ease of updates

List all medications, prescriptions, Over the Counter, Herbal, Vitamins, etc.

[illegible][illegible]